STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 067679

TICOR TITLE INSURANCE

MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

MOLLIE JEAN SCHALLER, being first duly sworn upon oath, deposes and says:

1. That MOLLIE L. PIERCE died on Nov. 24, 1998 at Munster Indiana.

2. That EUGENE W. PIERCE and MOLLIE L. PIERCE were duly and legally married at the time they acquired title as husband and wife to the following described real estate: LOT 54 IN PATTERSON'S 1ST ADDITION TO THE TOWN OF GRIFFITH, AS PER PLAT THEREOF, RECORDED IN PALT BOOK 33 PAGE 80 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of ~~(his)~~ (her) death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Mollie Jean Schaller
MOLLIE JEAN SCHALLER

SUSAN M. DOWNING NOTARY PUBLIC LAKE COUNTY, INDIANA EXP.

Subscribed and sworn to before me, a Notary Public, this 12TH day of SEPTEMBER, 19 2000.

FILED

SEP 15 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

Susan M. Downing
SUSAN M. DOWNING
Notary Public

My Commission expires:

4-10-07

County of Residence:

LAKE

00981 11.00 EP T.

This Instrument prepared by MOLLIE JEAN SCHALLER

92-4294

H/o Schwan's

Burn

TION ESTATE: The Social Security # is equested by this state agency in order to its statutory responsibility. Disclosure is ntary and there will be no penalty for refusal.

Local No. 2625-98

8205

PE/PRINT IN ERMANENT LACK INK

ECEDENT

ARENTS

FORMANT

SPOSITION

AUSE OF EATH

ERTIFIER

ALTH FICER

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
MOLLIE PIERCE	FEMALE	11:20 A M	NOVEMBER 26, 1998

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
332-14-3677	82			DEC. 20,1915	DECATUR.IL.

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	N/A	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☒ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	EUGENE PIERCE	REGISTERED NURSE	MEDICAL

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	GRIFFITH	728 N. GLENWOOD

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46319	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.		WHITE	12	4

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
JOHN CHARLES GRACE	PANSY SMITH

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
EUGENE PIECE	728 N.GLENWOOD GRIFFITH.IN.46319	HUSBAND

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	NOVEMBER 28,1998 CALUMET PARK CEMETERY	MERRILLVILLE.IN.

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
HENRY BLAKE	FD01019406	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
	FD01006015	FAGEN-MILLER FUNERAL HOMES 242 N.GRIFFITH BLVD.GRIFFITH.IN. FH8300275

26 PART I Enter the diseases, injuries, or complications that caused the death Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Congestive heart failure	1.5 days.
DUE TO (OR AS A CONSEQUENCE OF)	b. Pneumonia	2 days.
DUE TO (OR AS A CONSEQUENCE OF)	c. Renal insufficiency	12 days
DUE TO (OR AS A CONSEQUENCE OF)	d. Metastatic carcinoma of breast	10 yrs.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

NOV 30 1998

COPY OF THE CERTIFICATE OF DEATH ON FILE IN THE OFFICE OF THE LAKE COUNTY HEALTH COMMISSIONER

PART II Other significant conditions Conditions contributing to death but not previously stated in Part I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	No	N/o

29a CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated

☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated

☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Fred Adler M.D.	01019251	11/28, 1998

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

FRED ADLER, M.D., 800 MACARTHUR BOULEVARD, MUNSTER, INDIANA 46321

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Fred Adler M.D.	November 30, 1998

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	34f LOCATION (Street and Number or Rural Route Number, City or Town, State)

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

Ochman

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